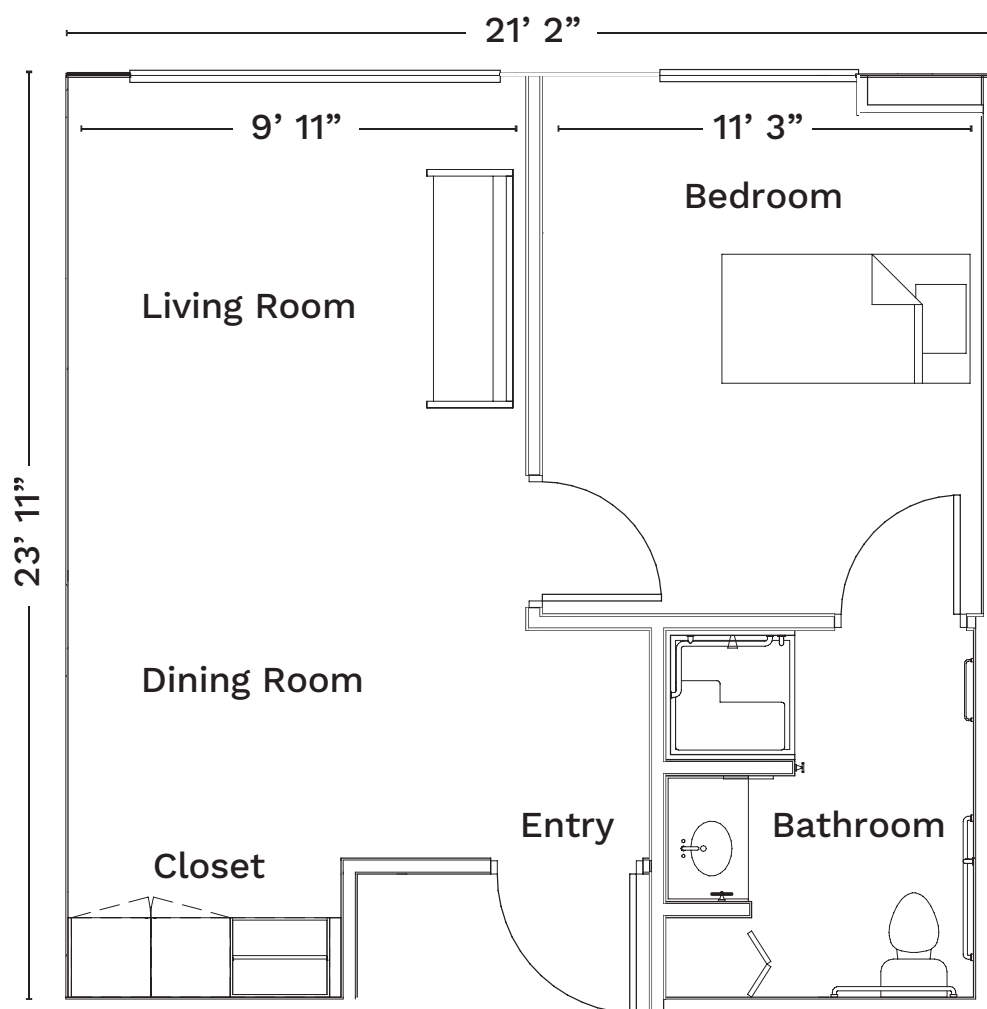


One Bedroom

475-514 SQ. FT.



DATE _____ RESIDENCE NUMBER _____ PREPARED BY _____

ONE-TIME COMMUNITY FEE	MONTHLY FEE	ESTIMATED LEVEL OF CARE*	OTHER
\$ _____	\$ _____	\$ _____	\$ _____

TOTAL MONTHLY FEE

\$ _____

*To be determined based upon clinical assessment